

COURT DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

ED MAR 28 1961

318

1003

2498-61-010907

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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| 1. PLACE OF DEATH a. COUNTY <u> </u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Lincoln</u> | | | | | | | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u> | | Length of stay in 1b <u>1 Week</u> | | c. CITY OR TOWN <u>Troy</u> | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | | | | | | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Luke's Hospital</u> | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) <u>one mile west of Troy</u> | | Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | | | | | |
| 3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>(NMN)</u> Last <u>Hagen</u> | | | | 4. DATE OF DEATH Month <u>March</u> Day <u>14</u> Year <u>1961</u> | | | | | | | | | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>White</u> | | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH <u>4/11/1880</u> | | 9. AGE (last birthday) <u>80</u> | | IF UNDER 1 YEAR Months _____ Days _____ | | IF UNDER 24 HR Hours _____ Min. _____ | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cabinetmaker & Machinist</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Inventing</u> | | 11. BIRTHPLACE (City and state or country) <u>Lustenau, Austria</u> | | 12. CITIZEN OF WHAT COUNTRY <u>USA</u> | | | | | |
| 13a. FATHER'S NAME <u>Unknown</u> | | | | 13b. MOTHER'S MAIDEN NAME <u>Unknown</u> | | | | 14. NAME OF HUSBAND OR WIFE <u>Ethel Hagen</u> | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> | | | | 16. SOCIAL SECURITY NO. <u>None</u> | | 17. INFORMANT Address <u>Mrs. Ethel Hagen, Troy, Missouri</u> | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Wound, penetrating gunshot, Brain, Right</u> <u>and left frontal lobe brain.</u> DUE TO (b) <u>Fracture, commin, Skull, Pt. frontal bone</u> DUE TO (c) <u>Pneumonia bronch. lectat. terminal</u> | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u> <u>7 days</u> <u>5 days</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>976+</u> | | | | | | | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input checked="" type="checkbox"/> HOMICIDE <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>as above</u> | | | | | | | | | |
| 20c. TIME OF INJURY Hour _____ s.m. _____ p.m. _____ | | Month, Day, Year <u>3-7-61</u> | | | | | | | | | | | |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Home</u> | | 20f. CITY, TOWN, OR LOCATION <u>Troy</u> | | COUNTY <u>Lincoln</u> | | STATE <u>Mo</u> | | | | | |
| 21. I attended the deceased from <u>3-7-61</u> to <u>3-14-61</u> and last saw him alive on <u>3-14-61</u> Death occurred at <u>5:10 P</u> m on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | | | | | | |
| 22a. SIGNATURE <u>Gray E. Louchee MD</u> | | | | 22b. ADDRESS <u>3720 Washington Ave. Springfield</u> | | | | 22c. DATE SIGNED <u>3-14-61</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal-auto</u> | | 23b. DATE <u>3/15/1961</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Troy City Cemetery</u> | | 23d. LOCATION (City, town, or county) <u>Troy, Missouri</u> | | 23e. (State) | | | | | |
| 24. FUNERAL DIRECTOR <u>Kemper-Marsh Funeral Home, Troy, Missouri</u> | | | | 25. DATE RECD. BY LOCAL REG. <u>MAR 15 1961</u> | | 26. REGISTRAR'S SIGNATURE <u>Loan Smith, M.D.</u> | | | | | | | |

OK
Paul
Dept of
3/15/61

APR 14 1961

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed Joseph P. Marabito

Licensed Embalmer No. 5105

P. O. Address Troy, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.